STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013582	A. BUILDING: _____ B. WING _____	03/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF LEBANON	610 CROWNPOINTE DRIVE LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for an Initial State Residential Licensure Survey. Survey dates: March 12 & 13, 2015. Facility number: 013582 Provider number: pending AIM Number: NA Survey team: Kewanna Gordon, RN-TC Megan Burgess, RN Census bed type: Residential: 44 Total: 44 Census payor type: Other: 44 Total:44 Sample: 5 Crownpointe of Lebanon was found to be in compliance with 410 IAC 16.2-5 in regard to the State Licensure Survey. Quality review completed 03/16/2015 by Brenda Marshall, RN.	R 000		